



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

February 23, 2007

Report Number: A-06-06-00094

Mr. Michael Robért
Internal Auditor, Finance and Operations
Tenet Choices 65
3838 North Causeway Blvd.
Suite 2200
Three Lakeway Center
Metairie, LA 70002

Dear Mr. Robért:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General (OIG), Office of Audit Services' (OAS) final report entitled "Tenet Choices 65's Adjusted Community Rate Proposal Modifications for Contract Year 2004."

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the department chooses to exercise. (See 45 CFR Part 5.)

Should you have any questions or comments concerning the matters in this report, please do not hesitate to call me or Cheryl Blackmon, Audit Manager at (214) 767-9205 or through e-mail at cheryl.blackmon@oig.hhs.gov. To facilitate identification, please refer to report number A-06-06-00094 in all correspondence.

Sincerely,

A handwritten signature in black ink, reading "Gordon L. Sato", is positioned above the printed name.

Gordon L. Sato
Regional Inspector General
For Audit Services

Enclosures – as stated

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**TENET CHOICES 65's
ADJUSTED COMMUNITY RATE
PROPOSAL MODIFICATIONS
FOR CONTRACT YEAR 2004**



Daniel R. Levinson
Inspector General

February 2007
A-06-06-00094

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

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In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

The Balanced Budget Act of 1997 (Public Law 105-33) established Medicare Part C, which offers beneficiaries a variety of health delivery models, including Medicare+Choice organizations. In general, these organizations assume responsibility for providing all Medicare-covered services other than hospice care for a predetermined capitated payment.

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) revised Medicare Part C, including changing the name of the Medicare+Choice program to Medicare Advantage and revising the payment rates to Medicare Advantage organizations (MAOs), effective March 2004. The MMA required MAOs to submit revised adjusted community rate proposals (rate proposals) to show how they would use the increase during contract year 2004.

Section 211 of the MMA (and section 604 of the Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000, incorporated by reference) allows MAOs to use payment increases to:

- reduce beneficiary premiums,
- reduce beneficiary cost sharing,
- enhance benefits,
- contribute to a benefit stabilization fund, or
- stabilize or enhance beneficiary access to providers.

Additionally, CMS instructed MAOs to substantiate all changes from the previous CMS-approved contract year 2004 rate proposal.

Peoples Health Network (Peoples Health) is a licensed third-party administrator that provides managerial and administrative services to Tenet Choices, Inc. (Tenet), a licensed health maintenance organization in Louisiana. On behalf of Tenet, Peoples Health administers a Medicare Advantage plan called Tenet Choices 65 (the plan). The plan provides Medicare services to members residing in the New Orleans metropolitan area. Peoples Health revised the plan's contract year 2004 rate proposal to reflect an estimated increase of about \$25.5 million in Medicare capitation payments because of the MMA legislation. Peoples Health proposed to use the payment increase to reduce beneficiary cost sharing, to enhance benefits, and to stabilize and enhance beneficiary access to providers.

OBJECTIVE

Our objective was to determine whether Peoples Health's use of its payment increase was adequately supported and allowable in accordance with the MMA.

SUMMARY OF FINDINGS

Peoples Health appropriately used the MMA payment increase to reduce beneficiary cost sharing, enhance benefits, and stabilize beneficiary access to providers by:

- eliminating the physical therapy and vision hardware copayments;
- reducing copayments on prescription drugs;
- waiving member enrollment fees for the prescription drug discount card; and
- increasing the percentage of premiums passed through to providers from 85 to 86.5 percent.

Peoples Health's use of the payment increase was adequately supported.

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INTRODUCTION

BACKGROUND

Medicare Advantage

Under Title XVIII of the Social Security Act, the Medicare program provides health insurance to people age 65 and over, people with end stage renal disease, and people with certain disabilities. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

The Balanced Budget Act of 1997 (Public Law 105-33) established Medicare Part C, which offers beneficiaries a variety of health delivery models, including Medicare+Choice organizations. In general, these organizations assume responsibility for providing all Medicare-covered services other than hospice care for a predetermined capitated payment. The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) revised Medicare Part C, including changing the name of the Medicare+Choice program to Medicare Advantage.

Rate Proposal Requirements

At the time of our review, Medicare regulations required each Medicare Advantage Organization (MAO) participating in the Medicare Advantage program to complete an annual adjusted community rate proposal (rate proposal) containing specific information about benefits and cost sharing. The regulations required MAOs to submit their rate proposals to CMS before the beginning of each contract period.

CMS used the rate proposals to determine whether the estimated capitation paid to each MAO exceeded what the MAO would charge in the commercial market for Medicare-covered services, adjusted for the utilization patterns of the Medicare population. The MMA required MAOs to use any excess to:

- reduce beneficiary premiums,
- reduce beneficiary cost sharing,
- enhance benefits,
- contribute to a benefit stabilization fund, or
- stabilize or enhance beneficiary access to providers.

Additionally, CMS instructed MAOs to (1) submit a cover letter summarizing how they planned to use the increased payments and (2) support changes to the original filing.

Federal Requirements

One provision in the MMA revised payment rates to MAOs, effective March 2004. CMS required MAOs with plans whose payment rates increased to submit revised rate proposals by January 30, 2004.

Peoples Health Network

Peoples Health Network (Peoples Health) is a licensed third-party administrator that provides managerial and administrative services to Tenet Choices, Inc. (Tenet), a licensed health maintenance organization in Louisiana. On behalf of Tenet, Peoples Health administers a Medicare Advantage plan called Tenet Choices 65 (the plan). The plan provides Medicare services to members residing in the New Orleans metropolitan area.

Peoples Health's Revised Rate Proposal

Peoples Health revised the plan's contract year 2004 rate proposal to reflect an estimated MMA increase of about \$25.5 million, or \$95.32 per member per month (PMPM).

Peoples Health proposed using the payment increase to reduce beneficiary cost sharing by \$13.11 PMPM¹, to enhance benefits by \$2.50 PMPM, and to stabilize and enhance beneficiary access to providers, which accounted for \$79.71 PMPM.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Peoples Health's use of its payment increase was adequately supported and allowable in accordance with the MMA.

Scope

Our review covered the estimated \$25.5 million increase in contract year 2004 Medicare capitation payments provided by the MMA legislation.

The objectives of our audit did not require an understanding or assessment of Peoples Health's or Tenet's internal control structure.

We conducted our fieldwork at the Peoples Health office in Kenner, Louisiana.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed the cover letter Peoples Health submitted with the plan's revised rate proposal detailing the expected use of the payment increase;

¹ Peoples Health actually stated that \$15.61 PMPM of the payment increase would be used to reduce beneficiary cost sharing. However, \$2.50 PMPM of this amount was actually a new benefit that was misclassified as reduced beneficiary cost sharing.

- compared the initial rate proposal with the revised rate proposal to identify the modifications;
- reviewed supporting documentation for the proposed use of the payment increase;
- reviewed supporting documentation for the actual use of the payment increase; and
- interviewed Peoples Health officials.

We conducted our review in accordance with generally accepted government auditing standards with one exception. Since there are no recommendations in this report, we did not issue a draft report for comment.

RESULTS OF REVIEW

Peoples Health appropriately used the MMA payment increase to reduce beneficiary cost sharing, enhance benefits, and stabilize beneficiary access to providers by:

- eliminating the physical therapy and vision hardware copayments;
- reducing copayments on prescription drugs;
- waiving member enrollment fees for the prescription drug discount card; and
- increasing the percentage of premiums passed through to providers from 85 to 86.5 percent.

Peoples Health's use of the payment increase was adequately supported.